NLR

UNION PACIFIC RAILROAD 0207JE0021

REPORT OF PERSONAL INJURY OR OCCUPATIONAL ILLNESS

FORM 52032
Rev. 01/04

INSTRUCTIONS: Answer all questions in each applicable section in your own handwriting as soon as possible after an accident/incident occurs if injured, either on or off duty or if you are reporting a work-related illness. (If unable to complete the report, necessary information must be furnished by the person doing so in the employee's behalf.)

SECTION I - EMPLOYEE INFORMATION

(1) YOUR NAME (First, Middle, Last)	(2) YOUR HOME ADDRESS	(3) CITY	(4) ST	(5) ZIP CODE
Robert Wayne Davis	8611 Woodhaven Drive	Pine Bluff	AR	71603

(6) YOUR OCCUPATION ON DAY OF INJURY	(7) YOUR HOME PHONE	(8) YOUR AGE	(9) HIRE DATE
FIREMAN+OILER Locomotive Moved	(870) 879-0477	55	04-23-74

(10) YOUR SOCIAL SECURITY NUMBER	(11) YOUR EMPLOYEE ID NUMBER	(12) YOUR SUPERVISORS NAME	(13) ASSIGNED REST DAYS
430-98-9601	0187560	John Lambe	SAT-SUN.

SECTION II - DETAILS OF ACCIDENT/INJURY

(1) DATE OF INJURY	(2) TIME	(3) WHERE WERE YOU INJURED (NEAREST CITY, STATE, RR LOCATION, ETC.)?	(4) TIME SHIFT OR TRIP BEGAN
2-13-07	12:20 ☐ AM ☑ PM	SERVICE TRACK North Little Rock, AR	7 00 ☐ AM ☑ PM

(5) MILE POST: SUB DIVISION: ☐ MAIN TRACK ☑ YARD

(6) WEATHER: ☐ CLEAR ☐ RAIN ☑ CLOUDY ☐ SLEET ☐ SNOW ☐ FOG ☐ OTHER TEMPERATURE 40°

(7) VISIBILITY: ☑ DAYLIGHT ☐ DARK ☐ DAWN ☐ ARTIFICIAL LIGHTING ☐ DUSK

(8) WERE YOU INJURED: ☑ ON DUTY ☐ OFF DUTY ☑ ON COMPANY PROPERTY ☐ OFF COMPANY PROPERTY

(9) SPECIFIC JOB OR ACTIVITY BEING PERFORMED AT TIME OF ACCIDENT/INJURY:
Outside Locomotive Hostling

SECTION III - DETAILS OF ACCIDENT/INJURY/OCCUPATIONAL ILLNESS

(1) DESCRIBE FULLY HOW THE ACCIDENT/INJURY OCCURRED:
Walking in Loose Rock Left ankle rolled to my Left side and I felt a pop in my Left Knee!

(2) WHAT SPECIFICALLY CAUSED THE ACCIDENT/INJURY:
Loose Rock! Very poor walking conditions!

(3) DID EQUIPMENT OR TOOLS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? ☐ YES ☑ NO IF YES, PROVIDE DETAILS (INCLUDING EQUIPMENT ID NUMBER)

(4) DID WORKING CONDITIONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? ☑ YES ☐ NO IF YES, PROVIDE COMPLETE DETAILS
Need much smaller Rock around switches and other areas where you have to walk a Lot!

(5) DID OTHER PERSONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? ☐ YES ☑ NO IF YES, PROVIDE COMPLETE DETAILS

(6) NAMES, OCCUPATIONS AND ADDRESSES OF ALL CREW MEMBERS AND/OR OTHER PERSONS WHO WITNESSED OR HAVE ANY KNOWLEDGE OF ACCIDENT/INCIDENT:
None

EXHIBIT
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CLIA

SECTION V - DESCRIPTION OF ILLNESS - PROVIDE ADDITIONAL DETAILS

(1) WHAT IS YOUR ILLNESS OR CONDITION?

6 S SO 10

(2) WHEN DID YOU FIRST BECOME AWARE THAT THIS CONDITION MAY HAVE BEEN CAUSED BY YOUR WORK? HOW DID YOU LEARN THIS?

(3) LIST ANY JOB(S), EXPOSURE(S), OR LOCATION(S) THAT YOU BELIEVE MAY HAVE CAUSED OR CONTRIBUTED TO YOUR SYMPTOMS (PLEASE PROVIDE DATES):

(4) DO YOU HAVE ANY CURRENT EXPOSURES? IF SO, PLEASE EXPLAIN:

SECTION VI - DESCRIPTION OF INJURY/OCCUPATIONAL ILLNESS AND TREATMENT

(1) DESCRIBE INJURY OR ILLNESS:
SPRAIN to Left Knee AND Left ankle!

(2) WHAT ARE YOUR SYMPTOMS?
Pain + Swilling to Left Knee + ANKle!

(3) WHEN DID YOU FIRST NOTICE SYMPTOMS? (GIVE DATE)
2-13-07

(4) WHEN WERE YOU FIRST TREATED OR DIAGNOSED?
Company NURSE 2-13-07 NLRST!; Baptist Hosp. ER 2-14-07

(5) PARTS OF BODY AFFECTED
Left Knee + ANKle!
SIDE OF BODY ☐ RIGHT ☑ LEFT ☐ BOTH

(6) WERE YOU EXAMINED BY A MEDICAL PROFESSIONAL? ☑ YES ☐ NO IF YES, GIVE MEDICAL PROFESSIONAL'S NAME AND ADDRESS:
James Rice MD Bapt Health Medical Center North Little Rock AR 72117

(7) TREATMENT REQUIRED: ☐ NONE ☐ FIRST AID ☑ TREATED & RELEASED ☑ X-RAYS ☐ HOSPITALIZED ☐ OTHER (Explain):

IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL Bapt. Hosp. ER

(8) WHAT TREATMENT WAS GIVEN?
Ice packs to Knee AND IBUPROFEN FOR PAIN + swelling!

(9) MEDICATION INSTRUCTIONS

WAS A PRESCRIPTION WRITTEN? ☐ YES ☑ NO IF YES: MEDICATION _____ DOSAGE _____

IF NO PRESCRIPTIONS WERE WRITTEN, WERE OTHER MEDICATIONS ISSUED OR RECOMMENDED?

☑ YES ☐ NO IF YES: MEDICATION IBUPROFEN 200mg DOSAGE 2 Every 4 Hrs

(10) INDICATE YOUR CURRENT HEALTH CARE COVERAGE PLAN: ☐ UPREHS ☐ UHC ☑ OTHER LIST:
United HeathCARe

SECTION VII - EQUIPMENT INVOLVED IN INJURY/ILLNESS (IF APPLICABLE)

(1) TRAIN SYMBOL	(2) ENGINE NUMBER	(3) CONSIST (Loads, Empties, Tons)	(4) IDENTIFYING INITIALS & NUMBERS OF EQUIPMENT INVOLVED IN ACCIDENT/INCIDENT

(5) WAS EQUIPMENT ON ☐ MAINTRACK ☐ YARD TIMETABLE DIRECTION_____

(6) WERE THERE ANY DEFECTS IN THE EQUIPMENT? ☐ YES ☐ NO

(7) IF THE ANSWER TO QUESTION 6 IS YES, STATE THE NATURE OF THE DEFECTS, IDENTIFY THE DEFECTIVE EQUIPMENT, AND COMPLETE (8).

(8) WERE THE DEFECTIVE CONDITIONS MARKED? ☐ YES ☐ NO

(9) DID THIS ACCIDENT/INCIDENT RESULT FROM RIDING ON, BOARDING, OR ALIGHTING FROM, OR BEING STRUCK OR RUN OVER BY MOVING EQUIPMENT? ☐ YES ☐ NO

(10) COMMENTS:

I certify that the foregoing information is true and correct.

Robert W. Davis
(Signature of Employee)

2-15-07 (FIS Feb20 07)
(Date Completed)

John Lambe
(Signature of Witness)

JOHN T. LAMBE
(Printed Name of Witness)